## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/22/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED  R-C 05/21/2012	
			A. BUILDING				
	155249		B. WING	B. WING			
	ROVIDER OR SUPPLIER  TRANSITIONAL CARE A	AND REHAB-FORT WAYNE	60	EET ADDRESS, CITY, STATE, ZIP CODE 106 BRANDY CHASE COVE DRT WAYNE, IN 46815			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	VIDER'S PLAN OF CORRECTION (X5) CORRECTIVE ACTION SHOULD BE EFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		
F 000	INITIAL COMMENTS		F 000				
	Paper compliance to complaint IN0010664 April 23, 2012.	0 completed on					
	Review Date: May 2 Facility Number: 000 Provider Number: 15 AIM Number: 10026	153 5249					
	Surveyor: Deborah M. Beers, R.N.						
	was found to be in co	Care and Rehab-Fort Wayne impliance with 42 CFR Part 10 IAC 16.2, in regard to the view to the complaint					
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  TITLE  (X6) DATE							

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.